Michigan

Implementing an Outreach Network and Control Program to Prevent or Delay the Onset of Diabetes

Public Health Problem

In 2000, the estimated number of adults in Michigan diagnosed with diabetes was 491,000, or 6.7% of Michigan's adult population. In addition, 574,800 Michigan adults aged 40–74 have prediabetes or impaired glucose tolerance (IGT). In 2000, diabetes was the sixth leading cause of death for Michigan residents. Diabetes-related medical care in Michigan exceeded $2.9 billion, with 60% of these costs attributed to hospitalization.

Evidence That Prevention Works

Multiple national and international studies have established the effectiveness of diabetes care improvement and patient self-management in reducing and delaying the onset of blindness, the need for foot or lower-extremity amputations, kidney disease, and many other diabetes outcomes. Recent diabetes prevention clinical trials have clearly demonstrated that among those with prediabetes, diabetes onset can be prevented or significantly delayed through modest improvements in nutrition, weight control, and exercise levels.

Program Example

The Michigan Diabetes Outreach Network (MDON) is composed of six regional Diabetes Outreach Networks. As part of this program, the networks have a Diabetes Care Improvement Project and work with over 150 agencies in the state. The agencies include physician offices, community health centers, home care agencies, state certified diabetes self-management education programs, and a range of other health care providers. The networks collaborate with the agencies to ensure that people with diabetes receive care according to current American Diabetes Association (ADA) clinical practice recommendations. Data are collected during the initial patient visit and follow-up appointments to determine how to improve care. The data through 2001 for A1C monitoring, foot exams, and microalbuminuria (kidney disease) assessments (all done at least once annually) show a significant improvement in the number of people with diabetes who have these tests done. In 2001, A1C tests increased from 14% in 1996 to 78%, and foot exams increased from 58% in 1996 to 77%. Microalbuminuria tests were added to the data system in 2000 and increased from 22% to 28% in the number of people tested between 2000 and 2001. MDON clients also reported significantly improved physical activity levels and nutritional planning.

Implications

Results from MDON demonstrate that working with health care agencies and providers through a statewide Diabetes Care Improvement Project can improve outcomes for people with diabetes. This program demonstrates that a regional network can play an effective role in helping to assure that all care provided to clients is based on ADA clinical practice recommendations.

Contact Information

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